



Ammonoosuc Community Health Services, Inc.
Patient Registration (Please Print)

ACHS 25 Mount Eustis Road Littleton, NH 03561
 WFHC 14 King's Square Whitefield, NH 03598
 MMHC 333 NH Rte. 25 Warren, NH 03279

ACHS 202 Cottage Street Littleton, NH 03561
 FFHC 155 Main Street Franconia, NH 03580
 ACHS 79 Swiftwater Road Woodsville, NH 03785

Name: (Last)			(First)			(Middle)			
Title:	Mr. <input type="checkbox"/>	Miss. <input type="checkbox"/>	Ms. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	Dr. <input type="checkbox"/>	Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Address: (Mailing)					(Residence)				
City:					State:		Zip Code		
Phone: (Home)			(Work)			(Cell)			
(Fax)			Email						
Birth Date: ____/____/____					Social Security #: ____-____-____				
Marital Status:		<input type="checkbox"/> Single-Alone		<input type="checkbox"/> Single w/partner		<input type="checkbox"/> Single w/children		<input type="checkbox"/> Single w/parents	
<input type="checkbox"/> Married		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed		<input type="checkbox"/> Separated		<input type="checkbox"/> Other	
Employment Status		<input type="checkbox"/> Full-time		<input type="checkbox"/> Part-time		<input type="checkbox"/> Self-Employed		<input type="checkbox"/> Retired	
<input type="checkbox"/> Unemployed		<input type="checkbox"/> Disabled		<input type="checkbox"/> Child		<input type="checkbox"/> STUDENT			
If Employed: Employer Name/Address: _____									
If you are a STUDENT , are you attending: <input type="checkbox"/> High School <input type="checkbox"/> College Highest grade completed _____									
How Should we contact you?					Letter <input type="checkbox"/>		Phone <input type="checkbox"/>		Fax <input type="checkbox"/>
									Email <input type="checkbox"/>
May we contact you at home?			Yes <input type="checkbox"/>		No <input type="checkbox"/>		May we contact you at work?		
							Yes <input type="checkbox"/>		
							No <input type="checkbox"/>		
If the answer is no to the above, with whom may we leave a message _____									
Phone (Home)					(Work)				
May we say "Ammonoosuc Community Health Services, Inc." is calling?							Yes <input type="checkbox"/>		No <input type="checkbox"/>

Preferred Pharmacy: _____					Primary Care Physician: _____				
Are you receiving WIC vouchers <input type="checkbox"/> Yes <input type="checkbox"/> No					Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you been seen at Dartmouth-Hitchcock Medical Center? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If you have been seen at Dartmouth-Hitchcock Medical Center, please ask to complete a release of information form									
How did you hear about our services?									
<input type="checkbox"/> Outreach		<input type="checkbox"/> Private MD		<input type="checkbox"/> Phone Book		<input type="checkbox"/> Media			
<input type="checkbox"/> Medicaid Office		<input type="checkbox"/> Nurse/Counselor		<input type="checkbox"/> Other Patient		<input type="checkbox"/> Health Educator			
<input type="checkbox"/> Hospital/Health Agency		<input type="checkbox"/> HMO		<input type="checkbox"/> Family/Friend		<input type="checkbox"/> Other Family Planning Clinic			

Emergency Contact:		Name:			Relation:		
Address: (Mailing)					(Residence)		
City:					State:		Zip Code
Phone: (Home):			(Work)			(Cell)	
Does contact know you are a ACHS patient			<input type="checkbox"/> Yes			No <input type="checkbox"/>	





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Treatment/Payment Agreement for Ammonoosuc Community Health Services:			
Primary Medical Insurance	_____		<input type="checkbox"/> Copy of card given
Insured Party	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent
Secondary Medical Insurance	_____		<input type="checkbox"/> Copy of card given
Insured Party	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent

Please complete this section *ONLY* if someone other than the patient is responsible for payment:

Party responsible for payment: _____ Spouse Parent Other: _____

Address:

Street _____ City _____ Zip code _____

Phone(Home) _____ (Work) _____ (Cell) _____

Home _____ Work _____ Cell _____

Social Security # _____ Date of Birth _____ / _____ / _____

Marital Status: Single-Alone Single w/partner Single w/children Single w/parents
 Married Divorced Widowed Separated Other

As a Federally Qualified Health Center, we are required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is not reported or disclosed.
Thank you for your cooperation!

Primary Language: English Spanish French Other _____

Translation needed: Yes No Are you a Veteran? Yes No

Household (If you are receiving prenatal or reproductive health services, you must list total gross household income and number of people in household)

Income: Total Gross Household Income: \$ _____ per week month year Decline to provide

Size: Number of people in household this supports: _____

Race White Black/African American Asian Other Pacific Islander
 Native American/Native Alaskan Native Hawaiian Multiracial Other _____

Ethnicity: Hispanic Non-Hispanic Decline to provide
 Homeless Migrant / Seasonal Worker Decline to provide

Acknowledgements:

Initial: _____ **Accuracy and Truthfulness of Information**
I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at ACHS and reporting of the failure to the federal government.

Initial: _____ **Medical Treatment & Release of Information and payment of claims**
I request ACHS to provide me and/or my family with medical care and request that ACHS bill my insurance company directly. I authorize release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits to ACHS

Initial: _____ **Patient Understanding of Financial Obligations of Patient to ACHS**
I understand that I am responsible for any deductibles, co-payments or non-covered service, and no-show charge, I understand that my failing to do so may result in my being submitted to collections, reported to the credit bureau, and / or terminated from services at ACHS

Initial: _____ **1) Patient Bill of Rights/Contract of Care. 2) Patient Discharge from Care Policy. 3) Notice of Privacy Practices**
I acknowledge that I have received from ACHS the: 1) Patient's Bill of Rights/Contract of Care. 2) Patient Discharge from Care Policy. 3) Notice of Privacy Practices

Patient Signature _____ Date / / _____